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Abstract

This article discusses the existence of a cultural and professional obsession with pathology which has jaded mental health assessments of consumers. The importance of incorporating ecological and strengths perspectives into the assessment process is discussed. It is suggested that individual and environmental strengths need to be taken into consideration for a more positive, respectful and empowering shift in assessment paradigms to occur. Deaf knowledgeable mental health professionals have an ethical obligation to consider the strengths and meanings of various d/Deaf, hard-of-hearing and late deafened realities as well as the individual's ancestral, cultural, spiritual and gender realities. A strengths based transactional deafness paradigm allows us to assess and incorporate the strengths and limitations of the person-environment fit and paves the way for a more humane and respectful approach to intervention.

Maria's Story

Maria, *an intelligent 37 year old hard-of-hearing single mother of three children, is looking for employment so that she can support her family. Maria is the daughter of Puerto Rican immigrants. She has much difficulty reading and writing English. She has had difficulty finding work. She did not finish high school. The cost of child care and transportation to any existing career training programs are beyond her means. She reports she is feeling depressed and powerless in her situation knowing that soon her welfare benefits are going to be discontinued.*

Mr. Thomas, a deaf clinician working in a community mental health center which provides services to deaf and hard-of-hearing people met for the first time with Maria. Mr. Thomas encouraged Maria to socialize more in the American deaf community to help her develop better American Sign Language skills. He referred her to a deaf English tutor who was caucasian and had no spanish language skills or knowledge of Puerto Rican culture.

Maria was ambivalent about these arrangements. She recalled many experiences with Americans, both deaf and hearing who were prejudiced towards Puerto Ricans. She and her family experienced much oppression as a result of these prejudiced attitudes. She did not feel welcomed by the American deaf community and she sees herself as hard-of-hearing since she had only a 45 decibel hearing loss. Mr. Thomas indicated in his assessment that Maria was resistant to helping herself and rejecting of American deaf people. After Maria's initial session with Mr. Thomas, she decided not to return for further sessions. She thought Mr.

Thomas was pushing her too hard to adapt to American deaf culture and sensed a judgmental attitude. She only had a few months of welfare left and Mr. Thomas was not addressing her more immediate and basic needs.

In Maria's story the realities of both deafness and non-deafness related environmental concerns needed to be assessed. The environment presented Maria with a series of barriers which she was attempting to overcome. This attempt on Maria's part to seek assistance, her intelligence, her ability to consider her children's needs and to prioritize, her self esteem, her persistence and survival in an oppressive environment, her ties to her Puerto Rican culture, and her ability to recognize her cultural position among deaf and hard-of-hearing people were all examples of her strengths.

In Maria's case, Mr. Thomas made the mistake of not exploring and acknowledging Maria's Puerto Rican culture, or the realities of her environmental circumstances. Mr. Thomas projected his own deaf American cultural values and beliefs onto Maria, viewing Maria's cultural realities as deficient and problematic. This prevented him from attending to her basic and immediate needs. He failed to consider the barriers that she would face in attempting access to the American Deaf community such as the attitudes of Deaf Americans towards a hard-of-hearing single mother who did not have good American Sign Language skills and the resulting emotional risk this would pose for her. The lack of sensitivity on Mr. Thomas's part was destructive to his professional relationship with Maria.

The Strengths Perspective

Historically, human service professionals have considered themselves "helping professionals". This label implies that the people we work with have problems, weaknesses, deficits, or pathologies, and that we have the skills, knowledge, superiority and authority to "help" or change them. Our culture is obsessed with pathology. Today, almost everyone is labeled as co-dependent, coming from a dysfunctional family, or as recovering from some sort of addiction, and professionals are perpetuating and profiting from this obsessional focus on the pathological individual (Saleebey, 1996).

Saleebey's (1996) *strengths perspective* transfers our attention to the positive qualities, skills, abilities, resources, and aspirations of the people we work with as well as those of the family, community and the larger social environment. By focusing on these positive attributes, mental health professionals are able to identify opportunities for empowering people using existing resources. By incorporating this perspective, assessment and intervention become possibility focused instead of problem

focused. Thus, mental health professionals conducting assessments should identify biological, psychological and social strengths of individuals as well as environmental strengths and resources.

Saleebey (1996) reminds us that adopting a strengths perspective does not mean ignoring problematic realities such as schizophrenia, child abuse, illness, addiction, etc. Rather, it frees us from the reign of psychopathology and perpetual projection of a sense of hopelessness onto the individuals we work with. The strengths perspective allows us to work with the strengths which our clients and their cultures possess. For example, a practitioner's focus on pathology could prevent him or her from seeing the potential that an individual who is mentally ill has for a college education and may cause the practitioner to ignore the person's stated goals and desires because of their belief that individuals who are mentally ill can not achieve these things. Incorporating strengths into assessment frames an empowering and esteem building treatment approach.

Transactional Assessment

Transactional assessment examines the person and their environment simultaneously (Longres,1997). As defined by Longres, transactional assessments require observation of the person in active interaction with other systems. Since it is not possible to actively observe people in all aspects of their environments the term is used more flexibly here to encourage practitioners to observe and assess the person's perspective of their interactions in various environmental contexts and to observe these interactions where it is possible. It also calls upon our ethical responsibility to continued professional education which advances our understanding of the dynamics of oppression and life circumstances of populations. The cultural, social, and linguistic realities of the dominant culture and those of the person's own culture are considered as interacting with each other. This makes for an ideal frame of reference for working with diverse populations and individuals who have experienced oppression.

Borrowing from the *ecological perspective* (Germaine, 1973), transactional mental health assessments take the social environment at all of its levels into consideration and allow us to understand the circumstances which influence the person's functioning and perspectives. The social environment includes "the actual physical setting that the society or culture provides" (Zastrow and Kirst-Ashman, 1997, p. 12) including interactions, circumstances, and conditions which influence our development, functioning, and survival. Originating from general systems theory (Bertalanffy, 1962), the ecological perspective examines resources and systems at micro (individual), meso (families and small groups) and

macro (societal, community, organizational, cultural, and political) levels and aims to enhance the goodness of fit between the person and the environment. Examining this person and environment interaction reduces the professional tendency to "blame the victim". For example, it may be possible to observe Maria in interaction with her children, and with her neighbors on a home visit, and it would be important to understand Maria's perspective of these interactions. It would also be critical to advance our understanding of the current and historical social conditions of Puerto Rican women in America to develop a more contextually accurate assessment of Maria's lifeworld, functioning and perspectives, her person in environment "fit" and how her transactions with these cultural environments impact upon her mental health.

Attending to a Multi-cultural Society and Deaf and Hard-of-Hearing Realities

While recent literature is replete with concerns about paternalistic (Lane, 1992; Lane, Hoffmeister & Bahan, 1996) treatment of deaf people, we have not given enough attention to, nor have we shown enough respect for, the heterogeneity and multi-cultural realities and experiences of individuals who are not culturally deaf. In addition, we have assumed that these paternalistic prejudices belong only to hearing people and hearing professionals.

In recent years, the number of deaf and hard-of-hearing clinicians in the mental health profession specializing in work with deaf and hard-of-hearing people has increased dramatically. This highly specialized population of professionals provides consumers with a new breed of qualified clinicians from which to choose. However, professionals who consider themselves experts in deafness and deaf knowledgeable are not exempted from the ethical obligation to explore and understand their own worldviews, communication, language, cultural preferences and realities, and educational philosophies and how this effects relationships with diverse clientele. Regardless of a mental health professionals hearing status, the attitudes and biases of the professional concerning the multiple realities of the person who is deaf or hard-of-hearing need to be monitored in the assessment process.

While it can be argued that there are advantages and disadvantages to any perspective on deafness, and some perspectives make for a stronger fit between the person and their environment, it is important for mental health professionals to look for the strengths that each of these perspectives presents in the lives of people who are deaf and hard-of-hearing. It may be that the culture, language, communication method or educational

philosophy of the consumer provides positive inter or intra-personal or cultural meanings and strengths which contribute to their well being. Professionals need to be cautious not to negatively assess a person based on differing cultural beliefs and meanings. This is particularly important when these beliefs and meanings reflect a goodness of fit between the person and their social environment. We must address, understand and respect these variables in a person's reality (Corker, 1994; Glickman, 1996). There are strengths to be found in every culture and in every individual. Sussman (1992) stated, "...the psychopathological perspective is rampantly manifest in the literature on deafness, especially in psychosocial aspects of deafness," (p. 2). He suggests, "...there are far more psychologically healthy and effective deaf people than there are not" (p. 3). I suggest, as Maria's story illustrates, that hard-of-hearing, late deafened, and deaf individuals who are not culturally deaf also have strengths that need to be recognized. Professionals need to attend to the strengths of these multiple realities.

In working with individuals who are deaf and hard-of-hearing, professionals must consider the wide range of deafness and non-deafness related developmental, environmental and systemic influences that accompany the person in their relationship with the mental health professional (Harvey, 1989). Clinicians need to be informed of various cultural implications for assessment.

The circumstances in Maria's story could be changed to match any cross cultural worker/client dyad (i.e., Puerto Rican hard-of-hearing worker and African American deaf client; white late deafened worker and Puerto Rican deaf client, etc.) and the same mistakes could have been made. People who are deaf and hard-of-hearing experience not just the cultural realities related to their hearing status, but also their racial, ethnic, gender, and spiritual realities and those of the majority with whom they interact.

Shifting Paradigms: A Strengths-Based Transactional Deafness Paradigm

It is critical that we recognize the consequences of such problem focused perspectives and adopt more humane, socially just, and empowering approaches to mental health assessment and practice. This article submits a *strengths based transactional deafness paradigm.* This paradigm proposes that in assessment we examine the person and their environments simultaneously and assesses the person and environment fit. It respects the worldview and cultural identity of the person; emphasizes practitioners' monitoring of cross cultural counter transference issues (i.e., hearing status, gender, sexual orientation, socio-economic class,

nationality, spirituality, culture, conceptualization of symptom manifestation, etc.); integrates concepts from strengths and ecological perspectives; deals realistically with limitations and problems; and reduces victim blaming.

Connie's story illustrates an effective application of this approach. Connie's situation contrasts Maria's in many ways. Connie and Maria have differing life experiences, perspectives, and realities and both meet with a clinician whose perspectives and experiences are quite different from their own. While Maria, who was hard-of-hearing, experienced an uncomfortable and unsuccessful session with her deaf clinician, Connie, who was deaf, had the opposite experience. Connie left her first session with a hard-of-hearing clinician feeling that it was a success and she looked forward to future sessions with Robert who employed a strengths based transactional deafness paradigm.

Connie's story: Connie, a bright young woman, was born deaf, attended a Catholic residential school for deaf students and communicates in American Sign Language. She graduated with honors from her high school. A devout Catholic, Connie was active with the Catholic deaf community. Her strengths included her determination not to let the prejudiced attitudes of others change who she really was and where she wanted to go in life.

Three years ago, Connie, her husband of four years, and young daughter were in an automobile accident. Her husband was killed in the crash. Connie was 7 months pregnant at the time and her son was born prematurely as a result of the accident. Connie began to experience chronic pain after the accident and two years ago her doctor diagnosed her with severe rheumatoid arthritis. She was referred to a specialist who confirmed the diagnosis.

Connie was working hard to get her life back in order. She had postponed career plans to care for their two young children while her husband attended college and began his own business. As a widow, she needed to make changes. She moved with her two children out of state to live with her parents where she sought Robert's help at a mental health center during a period of sadness.

Robert, was hard-of-hearing and ten years older than Connie. In contrast to Connie's Catholic upbringing, Robert was atheist. He was raised orally in hearing schools, speaks well, attended prestigious hearing universities and learned to sign during graduate school. Connie was concerned at first. Although she had no idea what Robert's religious beliefs were, she had previous experiences with oral, hard-of-hearing men who graduated from college which left her with the impression that they felt

superior to her. She wondered if Robert would see her for the capable, intelligent, outspoken person that she was, if he could accept and respect her deaf culture, her use of American Sign Language, and her goal to obtain her MBA, a traditionally non-female degree.

Connie had another story she hoped she would feel comfortable sharing with Robert. After the accident Connie began attending church more frequently and engaged in daily morning meditation and prayer. She appreciated and enjoyed these peaceful moments of solitude and prayer and reported that they had a calming effect on her. During one of these quiet prayer sessions, a few months after she had started them, Connie experienced a sudden and unusual tingling sensation in her neck and chest. It occurred to her that it felt as if she "had been touched by God", but thinking it was just her imagination, she left it alone.

At Connie's subsequent visits with her rheumatologist for the next three years, there was no trace of her disease and her pain had been noticeably decreased. Quietly, she wondered if this spiritual experience had been a healing one. Connie had shared this experience with a friend who joked that she had an hallucination and said the chronic pain she experienced probably didn't exist in the first place. This confused Connie. She had mixed feelings about telling Robert. She didn't know what his religious beliefs were or how he would "judge" her.

As Robert assessed and gathered this background information from Connie he shared with her that he recognized the trauma the accident had caused and the strength she showed in the process. He pointed out to her how it had taken courage and confidence to sacrifice her own career plans for her husband and family, especially in light of her many talents, and to move her family out of state. Robert recognized that there was ample opportunity in Connie's social environment to utilize these positive qualities within and beyond her immediate surroundings.

Acknowledging her confusion over her friend's comments, Robert pointed out to Connie that her faith and Catholic upbringing had served as a foundation for her in a time of need, as it does for many people, and that it appeared to be a source of important personal meaning and strength. Robert also discussed Connie's sadness as a normal part of her healing and suggested that their sessions could provide her with an opportunity to work through it if she wished to talk about it more.

Another thing which impressed Connie was Robert's suggestion that they write up the goals and objectives for their sessions together. She felt that they were on the same team, working together to identify strengths and resources which she, her children, parents and extended family, her church community, the deaf community and the larger society had to offer

as she and her children continued to recover from the loss of her husband. Aside from discussing the grief and interpersonal recoveries of Connie and her children, they also focused on her possibilities, listing among other things, a plan to apply for financial assistance to attend college and graduate school.

Connie felt empowered when she left her first session with Robert. She was pleased that Robert was non-judgmental, and respectful of her strengths and abilities, her possibilities, and her cultural and spiritual realities. She also felt encouraged by the resources they identified in her environment.

A positive and facilitative clinical relationship was formulated in this first meeting establishing a foundation for success in future sessions. Contributing factors included Robert's competencies, and the *strengths-based transactional deafness paradigm* which framed his assessment and planned interventions with Connie. Robert demonstrated respect and acceptance of Connie's cultural, linguistic and spiritual realities which were different from his own. He was able to recognize the strengths and meanings which these realities represented for Connie. Robert's assessment of and focus on Connie's strengths was affirming for her. At the same time, he was able help her deal realistically with her intrapersonal difficulties. Acknowledging the influence of the social environment on Connie's current and future situation also promoted a successful outcome.

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